RT

John Joseph Moakley
Courthouse
1 Courthouse Way
Boston, Ma.

ATTN: Judges LoBBy ; Judge Robert Collings / Judge Mr. Lindsey / Anita Palmucci

SHIRRON M. ADAMS

vs.

WASHington D.C.
White House and George W. BUSH

Legal status Chapter 123 Section 18A 9/8/05

Dear Mr. Judge Robert Collings

As we know I am my own ATTORney working on my case against my allegations of threat against Mr. Judge Lindsey.

I have been awarded a Transfer / Release upon my firing of my attorney Mr. Robert Murray.

I have been representing myself from the beginning of my case.

I am here at Worcester State Hospital

under an 18A. I sent you a letter (#2) sometime last week requesting for my release. I have an Appointment at the court on 9/12/05 and as my own Attorney and from my written request I would like to be officially freed. While here I have reported the pain and the assault and battery Placed on me from MCI Framingham. I also went into a bit of pain to my right Shoulder that I had to report while in Unmss Memorial Hospital after giving birth to my daughter.

I need you to officially set me free on 9/12/05 I will be owed by MCI Framingham for holding me past 30 days for approximately $5,750.00 - $5,850.00 upon my court date.

This money is critically needed to help [redacted] take care of myself and family.

This end of work the transfer/Release

has been completed. The Superintendent of MCI Framingham and John Joseph Moakley Court has been notified several times of me having to be released. (P3)

While here D.S.S. stepped in and tried to overside my Proxy that was signed on 8/31/05 ~~[illegible]~~ They ~~[illegible]~~ reported to me with a bogus 51A that supposed placed on me from the hospital (Unmass) of threatening to cause harm to my daughter my unborn daughter at the time. She was delivered on Sun. 9/4/05 her name is Shalicia Marie Adams-Ross They placed her in their care and custody they had no rights to do so. D.S.S. of Worcester.

I demanded that she be placed back home with my family.

I specifically told the hospital that there is a Proxy in effect and my Court

(4)

Tonya Adams/Samuels and her Husband Mr. Richard Samuels is to care for her while I take care of my court issues. Her Address and Telephone numbers (617) 436-5425; 363 Quincy St. Apt #2 Dorchester Ma. 02125.

Please check on my daughter and my family and make sure she is home.

Legal status conditional Voluntary (MGL Chapter 123, Section 10)

Treatment at Worcester State Hospital is based on the bio/psychosial model of Mental illness. In this model, mental illness is viewed as having biological, psychological, and social causes - Treatment is designed to reduce each patient's symptoms and to improve the situations that make hospitalization necessary.

This falls in line with my complaint and issues with the White House and George W. Bush that I have there in court.

(P5)

IF my request for full voluntary Services is honored I will be needing all exams that are required by this hospital to give upon admissions ROUTINE AND PREVENTATIVE Treatment/ Physical EXAM

I would like to be moved to another unit and have a new Treatment team. Possibly an Extended Care Adult unit for Intensive Stabilization Treatment Planning.

Before anything is put in Place MCI Framingham has got to be Officially eliminated out of the picture and I will be needing Some kind of Legal Services put into Place.

I've already written the American Civil Rights Union; 99 Chauncey St. Boston, Ma. I am now waiting for them to come into effect.

I need the entire harassment to end for Good.

(PL)

This is a Life threatening situation I have complained numerous times in and at every facility that I have been placed in.

I also know that I have Access to Legal Advocacy Organizations here Possibly the Committee for Public Counsel Services if they can possibly provide me the free Legal assistance and do an efficient JOB for such a complicated and sofisticated case. I do prefer the American Civil Rights Union above all the rest.

While I am here I am excersicing my patient rights.

No one is aloud in here to see me unless they are my family, attorney or advocate, ~~Guardian~~ or boyfriend. (Child's/children's father) No one else.

If I am to be here I will also be needing help with Residential upon discharge. I would be Looking for

(87)

something along the lines of privacy like supported apartments. I would like to get the proper care that is needed emediately while I am here.

If you choose to move me closes to Boston to another DMH I have no arguments, bcet I do want the wires removed from my body and all other harassments to stop emediately also.

I have Human Rights and I will not allow them to be violated in any shape form or fashion

Please honor.

Sincerely Yours,

Ms. Stirron M. Adams
305 Belmont St.
Worcester, Ma. 01604
WARD 1A

COMMONWEALTH OF MASSACHUSETTS
THE TRIAL COURT

WORCESTER DIVISION

PROBATE & FAMILY COURT DEPT.
DOCKET NO.: 05P2518-GI1

GUARDIANSHIP OF

SHIRRON ADAMS

NOTICE OF HEARING PURSUANT TO PROBATE COURT RULE 29B

PLEASE TAKE NOTICE that, after hearing on September 1, 2005, Judge Delise Meagher of this Court made findings and appointed Anita Palmaccio, Esquire to serve as temporary guardian of the person for Shirron Adams for a period of ninety (90) days. The notice requirements for this hearing were waived because of the ward's current medical and psychiatric condition. Because the notice requirements were waived, the undersigned is required to notify the ward and all other interested parties of the Court's decision. The undersigned also is required to notify the ward and other interested parties that, if they wish, any of them may petition the Court to vacate its decree or take any other appropriate action. Please consider this document to be such a notice.

Respectfully submitted,
DEPARTMENT OF MENTAL HEALTH
by its attorney,

Stephen Shull
DMH Central Mass. Area Legal Counsel
DMH Central Mass. Area Legal Office
305 Belmont Street
Worcester, MA 01604
(508) 368-3500
BBO # 460290

AFFIDAVIT OF NOTICE

I hereby affirm under the penalty of perjury that, pursuant to Probate Court Rule 29B, a copy of the foregoing notice was delivered in hand to the ward and that copies were mailed to the other interested parties by mailing copies to: Anita Palmaccio, Esquire, P.O. Box 648, Lancaster, MA 01523, Jacquelyn Whitcomb, 7 State Street, Worcester, MA 01609, and Robert Murray, Esquire, 225 Friend Street, Boston, MA 02114.

Respectfully submitted,

Date

Stephen Shull
DMH Central Mass. Area Counsel

Noticed actioned sent 9-3-05

Billings 9/9/05

I am sending a copy of the Billing Charges here in which would probably be expected for me to pay for Worcester state Hospital.

It is A clear picture of the billing statement that would be possibly used at another DMH services.

I am clearly in need of my settlement assets to be released through the courts.

I have Bills to pay and if is also a matter of Basic Human rights.

I have children and myself to support.

I will be using Family Services of Greater Fall River still as my rep. Payee.

9/9/05

I have Bills there that still need to be paid.

I have a family just as you do and I do my best to help support and support indeferately my own Children.

I have sent a letter to my ex-Attorney Mr. Douglas Sorenberge requesting that he sends my letter of appeals to the proper address because that information is not provided here.

I spoke with him to let him know that I sent it out to him.

I am currently waiting on my answer from the Courts and I am expecting a Court date.

The Case is pertained to The Commonwealth of Mass. Dorch. Dist. Court for Assault and Battery.

9/9/05

Mr. Joven Burge of Bon Bordo and Joven Burge Assoc. had recieved a dismissal by the courts I written a letter for a motion to appeal.

I also written my Guardian here for DMH services that was appointed to me by the courts to assist me with my legal actions and to check in on my case.

I am looking to hear from her soon.

Sincerely Yours

Ms. Sherron M. Adams
305 Belmont St.
Worcester, Ma. 01604
WARD 14

12. NOTICE OF CHARGES - Worcester State Hospital
For Fiscal Year 2005 (July 2004 to June 2005)
This notice is required to be given to you at admission.

In accordance with 104 CMR 30.04, the Department of Mental Health (DMH) is authorized to charge for the care, treatment and other services provided to any individual who receives services provided by a DMH-operated facility or a DMH-operated or contracted program, whenever any such care, treatment or other service has a charge associated with it.

You are receiving (or will receive) care, treatment or other services from the facility or program named above. This facility or program has established the following charges for the care, treatment and other services it provides:

SERVICE	BILLING UNIT	CHARGE
Primary Acuity (4D,1A, 3A/D)	Bed Day	$ 619.00
Secondary Acuity (2A, 2D, 4A, 5B, 6A, Cott.4)	Bed Day	$ 535.00
Transitional Acuity (Cottage 3)	Bed Day	$ 493.00
Laboratory	**Procedure**	**$ Cost**
Radiology	**Procedure**	**$ Cost**
EKG/EEG	**Procedure**	**$ Cost**
Occupational Therapy	**10 minute**	**$ 34.00**
Psychology	**10 minute**	**$ 19.00**
Speech	10 minute	$ 45.00
Physical Therapy	10 minute	$ 68.00
Professional Service – Physicians	Procedure	$ 157.00
Professional Service – Clinical Psychology	Procedure	$ 157.00
Professional Service – Nurse Practitioner	Procedure	$ 157.00

You, and any other person(s) financially responsible for your care, if any, have the right to receive a copy of the DMH "Charges for Care" Policy 98-1, which governs and explains charges and adjusted charges for services received. You also have the following rights regarding payment for those services:

1. The right to have the charge adjusted based on your personal circumstances (or the circumstances of another financially responsible person(s), if any). The Department representative listed at the end of this form will contact you and, if applicable, the other financially responsible person, to collect information necessary to determine what adjustments should be made, if any, to the approved charges.

2. The right to review the financial information about you that was used to determine the adjusted charge and to receive an explanation of how the adjustment was determined. You may submit additional financial information, if you wish, or challenge the accuracy of the financial information the Department used in making its determinations and request a redetermination of your adjusted charge.

3. The right to request a redetermination of the amount of the adjusted charge due to changes in your financial circumstances.

4. The right to pay on a budget plan.

5. The right to appeal the amount of the adjusted charge to the Chief Operating Officer or Area Director or designee, within 21 days of being notified of the amount due. The right to be assisted by a person of your choice during the appeal process.

6. If you choose to appeal, your appeal will be heard by the Chief Operating Officer or Area Director or designee, in accordance with the procedures for such appeals that are set out in the Department's regulations 104 CMR 30.04 (10).

Your Treatment Team

1. **You Are On Ward:** 1A
2. **Your Psychiatrist is:** Tina LuSignolo
3. **Your Physician is:** Amy Pinkham + Dr. Bazemore
4. **Your Social Worker is:** ALBERTO
5. **Your Team Nurses are:**
   - **Morning Shift (7am-3pm)** Debbie N. - Carol K. - Dawn H.
   - **Evening Shift (3pm-11pm)** Betty G. - Kathy K.
   - **Overnight Shift (11pm –7am)** Robin R.
6. **The Rehabilitation Staff are:** Rajoo
7. **Your Psychologist is:** Les M.
8. **YourTeam Mental Health Workers are:**
   - **Morning Shift (7am-3pm)** Winston, Joie, James, John, Kris
   - **Evening Shift (3pm-11pm)** Nell- Matt- Gladys- Does
   - **Overnight Shift (11pm –7am)** John- Sam - Winifred - David
9. **Other Staff:**

10. **Worcester State Hospital telephone number:** (508) 368-3300
11. **Pay Phone Number:** (508) 798-9333 - 508-799-6820
12. **Ward Phone Number at Nursing Station:** (508) 368-3481

Human Rights and Patient Advocacy Offices

Human Rights Officer:	Kevin Howley ext. 83444 Room 1D7
M-Power Office	1-877- 769-7693

Special Assistant for Human Rights	25 Staniford St. Boston, MA	617-626-8107
Office of Client and Ex-Patient Relations	25 Staniford St. Boston, MA	617-626-8065
Center for Public Representation	246 Walnut St. Newton, MA	617-965-0776
Mental Health Legal Advisors Committee	294 Washington St. Suite 320 Boston, MA	
		617-338-2345 or 1-800-342-9092
Disability Law Center	11 Beacon St. Suite 925 Boston, MA	
		617-723-8455 or 1-800-872-9992
Legal Assistance Corporation of Central Mass.		508-752-3718 x3037
Worcester State Hospital Legal Advocate	Christine Griffin	1-800-872-9992

GUARDIAN – STANDBY AND EMERGENCY PROXY

In accordance with M.G.L. Ch. 201, sec. 2G, I Shirron Adams and I, _____
100 Green St, Fall River, MA 02720 do hereby appoint Tonya Adams of
363 Quincy St, Dorchester, MA 02125 Guardian - Standby and Emergency Proxy for my/our unborn child. This Guardian - Standby and Emergency Proxy shall become effective upon his or her birth.

EFFECTIVE DATE: (fill in date of birth) _____

By executing this document, I/we understand that Tonya Adams shall have, with me/us, concurrent authority to act as guardian for my/our child for a period of sixty (60) consecutive days from the date written above.

~~I certify that there is no other living parent whose parental rights have not been terminated, whose whereabouts are known and he is willing/able to make and carryout day to day child care decisions.~~

Signature: _____ Date: 8/31/05
(parent)

and/or

Signature: _____ Date: _____
(parent)

Witness Statement: We, the undersigned, each witnessed the signing of this Guardian – Standby and Emergency Proxy by the Parent(s), or at the direction of the Parent(s), of the minor who is the subject of this instrument. We are each eighteen (18) years of age or older.

Witness #1
Signature: _____ LICSW Date: 8/31/05
Name (print): Adalberto Rivera Vega (IA)
Address: 305 Belmont St
Worcester, MA 01604

Witness #2
Signature: _____ Date: 8/31/05
Name (print): Betty Gladden
Address: C/: WSH-IA 305 Belmont St
Worcester, MA 01604

Proxy Statement: I, the undersigned, hereby accept the appointment as Guardian – Standby and Emergency Proxy for the minor who is the subject of this instrument.

Signature: _____ Date: _____
(Proxy)

Acknowledgment of Receipt

I, _____, Guardian-Standby and Emergency Proxy, acknowledge receipt from UMass Memorial Medical Center of _____. Date of Birth: _____
(name of the minor who is subject of this instrument)

Signature: _____ Date: _____
(Proxy)

Signature: _____ Date: _____

Updated 8/10/01

9/9/05

Personal Request

Due to the harassment and vicious targeting I am requesting in writing that my family emediate Family that I have mentioned on and In my will that is held by Family Services of Greater Fall River is that the jails and Prisons stay away from me and my family.

If any serious crimes are committed please admit to DMH services.

Too many Lies and Conspiracies.

Written in request for our safety

Sincerely Yours,

Mr. SAMSON M. Adams
305 Belmont St.
Worcester Mass. 01604
WARD 12

Commonwealth of Massachusetts
Department of Mental Health

APPLICATION FOR ADULT CONTINUING CARE SERVICES (Jun 20, 2003)

SECTION 1: PERSONAL INFORMATION – completed by the applicant, his or her legal guardian, or someone assisting the applicant

1. Name Adams (Last) Shirron (First) M. (Mi) 2. SSN 011-56-7655 (Social Security Number)

3. Address 16 Slayton Way (Number and Street) Roxbury (Apt No) (City) MA (State) 02119 (Zip Code)

4. Telephone (617) 445-5602 (day) ( ) (evening) message

5. Birth Date 05/17/74 (MM / DD / YY) 6. Age 31 (In Years) 7. Gender F M / F 8. Race/Ethnicity African-American

9. Does applicant speak English? ☑ Yes ☐ No ☐ Limited 10. Preferred Language/Dialect English

11. Literate in English? ☑ Yes ☐ No ☐ Limited
11a. Literacy in the applicant's native language? ☑ Yes ☐ No ☐ Limited

12. Citizenship US 13. Country of origin US 14. Length of stay in U.S. 31 yrs

15. Religion Christian

16. Does applicant have a court appointed legal guardian? ☐ Yes ☒ No

17. Name of legal guardian _____ (Last) _____ (First) Relationship _____ (to Applicant)

18. Telephone ( ) _____ (day) ( ) _____ (evening)

19. Emergency contact person _____ (Last) _____ (First) 20. Telephone ( ) _____

21. **HEALTH INSURANCE** a) ☑ No health insurance b) ☐ No mental health benefit

c) ☐ Application for Health Insurance Pending

d) ☐ Medicare e) ☐ Medicare/Medicaid

f) ☐ Medicaid/MassHealth Card #: _____ g) RID #: _____

MassHealth Provider
h) ☐ HMO _____ (Name of HMO) i) ☐ Primary Care Clinician Program (PCC) j) ☐ Other _____

k) ☐ Private insurance l) Name of Insurance: _____ m) Policy #: _____

n) Name of Policy Holder: _____

22. **SOURCE OF INCOME**

a) ☐ Employment b) ☐ SSDI c) ☐ SSI d) ☐ EAEDC e) ☐ Social Security f) ☐ Family

g) ☒ Other sources If other, explain: Frozen by Federal Govt. h) Estimated Personal Monthly Income: Ø

Applicant Name:

Applicant Name:

AUTHORIZATION FOR DMH ELIGIBILITY DETERMINATION

- I request that the Department of Mental Health (DMH) conduct a determination of eligibility for continuing care services. I have attached signed release of information forms to this application if necessary. I understand that DMH will collect and review medical records as part of the determination of eligibility. I understand that my name and information about me will be included in a DMH record keeping system.
- DMH may, at its discretion, request a personal interview with me or a clinical evaluation in circumstances where the available clinical records are not sufficient to make a determination of eligibility.
- In addition, I will be required to disclose information about my income and insurance and may be charged for services according to my ability to pay.
- I also understand that I may appeal the decision of DMH in determining whether or not I am eligible for DMH continuing care services.
- I received a copy of the DMH Notice of Privacy Practices (appended to this application)

X _____ Shirron Adams 8/25/05

Signature of applicant or legal guardian of the person | Applicant Name (Print) | Date signed

PERSON ASSISTING APPLICANT

This section to be completed by provider or other person assisting applicant with the application.

Name Rivera-Vega (last) Adalberto (first) Relationship Soul Worker (relationship to applicant)

Address 305 Belmont St. (number and street) 1A (apt no) Worcester (city) MA (state) 01604 (zip code)

Telephone (508) 368 3486 (day time) ( ) _____ (evening)

PROGRAM OR FACILITY SUBMITTING APPLICATION ON BEHALF OF APPLICANT

This section to be completed by program or facility submitting application on behalf of applicant

_____ Name of Program or Facility

_____ Name of Applicant

☐ The applicant was informed on _____ that an application was being filed on his/her behalf and he/she did not object

☐ The applicant is incapable and a petition for guardianship was filed in the appropriate court (copy of petition is attached)

_____ Your Name (please print)

_____ Your Signature and Title

TO SUBMIT RELEASE OF MEDICAL INFORMATION FORMS

As part of the determination of eligibility, the Department of Mental Health will review records of all mental health care provided to the applicant during the past 24 months.

1. Please submit one signed *Authorization for Release of Information* form for each provider of mental health care during the past 24 months. If mental health care was provided through a clinic, please identify a primary provider of care at that clinic.
2. In addition, please submit an *Authorization for Release of Information* form for any other clinical information the applicant would like to have considered as part of the determination of eligibility.
3. Please double check the accuracy of the provider's name, address, and phone number on each release form. Please make a phone call if necessary to verify information on the *Authorization for Release of Information* form. Correct names and addresses expedite the eligibility review process.
4. Please submit signed *Authorization for Release of Information* forms along with the application, if possible.

How many *Authorization for Release of Information* forms are being submitted with this application? 6

The Department will also review any medical records that the applicant or those assisting the applicant may have in their possession and wish to submit for consideration.

1. Please complete and sign an *Authorization for Release of Information* form for each medical record that is attached to this application in case DMH staff need to clarify information contained in the report.
2. Copies of medical reports cannot be returned so please do not send original copies.

How many copies of medical reports are attached to this application? ☐

Commonwealth of Massachusetts
Department of Mental Health

APPLICATION FOR ADULT CONTINUING CARE SERVICES **(June 20, 2003)**

INSTRUCTIONS:
This form is for applicants **19 years of age or older**.

The applicant, his or her legal guardian, or someone assisting the applicant, should complete →**SECTION 1**.

A treating clinician or other person with knowledge of the applicant's history should complete →**SECTION 2** of the application and the →**CLINICAL ASSESSMENT OF RISK, BEHAVIOR AND REHABILITATION NEEDS OF ADULTS**.

These sections and the signed →**AUTHORIZATION FOR DMH ELIGIBILITY DETERMINATION** must be returned to the Department of Mental Health Eligibility Unit serving the applicant's area of the state.

DMH Eligibility Units:

Western Massachusetts Area Eligibility Determination Unit
P.O. Box 389, Northampton, MA 01061-0389
Phone: (413) 587-6200 Fax: (413) 587-6205

Central Massachusetts Area Eligibility Determination Unit
305 Belmont Street, Worcester, MA 01604
Phone: (508) 368-3838 Fax: (508) 363-1500

Metro Suburban Area Eligibility Determination Unit
P.O. Box 288 – Lyman Street, Westboro, MA 01581
Phone: (508) 616-2186 Fax (508) 616-3599

North East Area Eligibility Determination Unit
P.O. Box 387, Tewksbury, MA 01876-0387
Phone: (978) 863-5000 Fax (978) 863-5091

Metro Boston Area Eligibility Determination Unit
85 East Newton Street, Boston, MA 02118
Phone: (617) 626-9217 Fax: (617) 626-9216

Southeastern Area Eligibility Determination Unit
165 Quincy Street, Brockton, MA 02302
Phone: (508) 897-2000 Fax (508) 897-2024

DMH Information and Referral service: 1-800-221-0053 (regular business hours only)

DMH web site: www.state.ma.us/dmh

9/9/05

P.S.
While in hospital I will be needing my tubes tied the paperwork is already in effect from Umass Memorial here in Worcester.

Sincerely Yours,

Ms. Shirley M. Adams
305 Belmont st.
Worcester, Ma. 01604
Ward 1 A